Economic and Social Rights Advocacy (ESRA) Brief

April 2015 - Issue 4

Getting it Right:

Uganda’s Proposed National Health Insurance Scheme
Acknowledgment

The Economic and Social Rights Advocacy (ESRA) Brief is a biannual publication of the Initiative for Social and Economic Rights (ISER) whose goal is to create awareness, encourage and stimulate national debate around social economic rights as well as act as a knowledge exchange platform for stakeholders and the broader Ugandan populace.

Special thanks to the Public Interest Law Clinic (PILAC) of the School of Law at Makerere University for availing and supervising students who worked on the analysis of the Proposed National Health Insurance Bill 2012.

To contribute to future editions of ESRA brief, email the editors at info@iser-uganda.org

ESRA brief is also available online at www.iser-uganda.org

Executive Director: Salima Namusobya

Editors: Angella Nabwowe and Nokukhanya Mncwabe

Photography: Shujja Konsults

Design and Layout: Shujja Konsults

The ESRA Brief is published with support from

[Logos of the supporting organizations]
1. Introduction: Getting it right: Uganda’s Proposed National Health Insurance Scheme. Pages 3 - 4

2. The future of health insurance in Uganda: A critique of the proposed National Health Insurance Bill 2012. Tendo Ann, Orikiriza Fiona, Emwogu Gerald, Mugabe Oscar & Muhumuza Duncan Itu - Year 3 Bachelor of Laws students attached to the Public Interest Law Clinic (PILAC), School of Law, Makerere University. Pages 5 - 11

3. To learn to swim, you have to jump into the swimming pool: Interview with Dr. Francis Runumi, Chairperson of the National Task Force of the Proposed National Health Insurance Scheme/ Commissioner for Planning at the Ministry of Health. Pages 12 - 13

4. Is the National Health Insurance Scheme ill-conceived? Lucas Barthelemy. Pages 14 - 17

5. “We can learn along the way”: Q and A with Dr. Asuman Lukwago: Permanent Secretary, Ministry of Health. Pages 18 - 20


7. NSSF willing to provide health insurance to members: Moses Talemwa, Editor – The Observer Newspaper. Pages 23 - 26

8. Borrow lessons from Rwanda: Interview with Ms. Rosemary Senabulya, Executive Director of the Federation of Uganda Employers. Pages 27 - 28

9. Go Slow: Interview with Mr. Everisto Kayondo, Chairperson of Kampala City Traders Association (KACITA). Pages 29 - 30

10. Citizen voices: Ordinary Ugandans speak out on the proposed National Health Insurance Scheme. Joshua Kisawuzi, Community Outreach Officer, ISER. Pages 31 - 32


13. Drawing from the experiences of community health schemes in Kanungu and Rukungiri districts: Fiona Orikiriza, Year 3 Bachelor of Laws student attached to the Public Interest Law Clinic (PILAC), School of Law, Makerere University. Pages 37 - 40


15. Concerns over Kenya’s financing for Universal Health Coverage that Uganda could learn from: Dr. Vincent Okungu, consultant health economist and academic. Pages 44 - 45
Globally, the World Health Organization (WHO) has been pushing for universal health coverage. According to WHO, the goal of universal health coverage is to ensure that all people obtain the health services they need without suffering financial hardship by having to incur out of pocket expenses to pay for said services. Looking at the post 2015 health agenda, WHO notes that universal health coverage is a way of ensuring continued progress towards the current health Millennium Development Goals (MDGs), while also helping countries address the growing threat of non-communicable diseases, mental illness and injuries.

The Ugandan Ministry of Health is currently awaiting a certificate of financial implication from the Ministry of Finance, Planning and Economic Development in order to proceed with the proposed National Health Insurance Bill 2012, which once adopted, will operationalise the National Health Insurance Scheme (NHIS). This is a commendable step towards the realization of the right to the highest attainable standard of physical and mental health in the country. However, as the process unfolds, the Initiative for Social and Economic Rights (ISER) deemed it fit to speak to a number of stakeholders to ensure representation of their priorities and concerns.

In this edition of the ESRA brief, we provide a comprehensive review of the proposed NHIS Bill 2012, from a human rights perspective to gauge the following: is Uganda’s NHIS, in its current form, a positive development or is it ill conceived. Our assessment examines factors including but not restricted to healthcare infrastructure and human resources, implementation of medical insurance, financing and inclusiveness.

The brief also considers how participatory, or not, the process has been thus far? Dr. Francis Runumi, architect of the NHIS in the Ministry of Health (MoH) asserts that it is time to jump into the pool if we wish to learn how to swim, instead of standing on the sidelines and continually deliberating on the matter. His sentiments are echoed by MoH Permanent Secretary Dr. Asuman Lukwago, who says consultations can be perpetual and wants to get the scheme started with the recognition that there is much to be learned along the way. The selected Members of Parliament, whom we spoke to, concurred that the scheme is long overdue. They provided valuable information to aid successful implementation, drawing on lessons from the countries to which they conducted benchmarking visits.

A number of concerns were raised regarding the potential of the scheme to increase the cost of doing business in the country, since it proposes a 4% contribution from formal sector employers and employees respectively. We now also have it on record that the National Social Security Fund (NSSF) is seriously looking into the provision of health insurance coverage for
its members, their spouse and two children.

The National Federation of Employers Uganda wants Uganda to follow the Rwanda example and establish three schemes: one for the public sector, another for the private sector, and a third for the informal sector. They are against imposing an additional burden on employers and employees considering that they are already contributing towards social security. They propose that a percentage from the 15% contributed to NSSF be used for this purpose but this would require an amendment to the NSSF Act to include health among the benefits offered by the fund.

Kampala City Traders Association (KACITA) cautions the MoH from rushing implementation of the Scheme, warning that it risks having the policy rejected if consultations on it are not widely conducted.

We also spoke to some ordinary Ugandans about their views on the proposed scheme but many had no knowledge of it.

We bring you local best practices on successful community health insurance schemes implemented in Rukungiri and Kanungu districts in Western Uganda. An indigenous group, the Batwa, is one of the beneficiaries of the community health insurance schemes. We also present to you insights and lessons from Ghana and Kenya's experiences of implementing a national health insurance scheme.

A common factor identified by all contributors, is the need to ensure that poor and marginalized people are included in the scheme. This is flagged as a major concern, particularly as the scheme in its current formulation proposes to start by enrolling and providing coverage to civil servants and formal sector employees. Under the scheme, it is envisaged that other categories, the informal sector and indigents inclusive, will be brought on board at a later stage; however, no clear indication has been provided as to when this will happen. As ISER, we have the perspective that no one should be left behind in Uganda’s effort to provide comprehensive, quality and affordable access to healthcare.
The future of health insurance in Uganda: A critique of the proposed National Health Insurance Bill 2012

Authors

Introduction
In Uganda, the most common way of accessing health services, is to incur the costs out of pocket: in other words, when a person falls sick they – or their loved ones – have to pay for medical services and treatment from their savings or acquire the means some other way, for example selling something, borrowing informally or taking on a formal loan. Some communities have instituted Community Based Health Insurance Schemes to spare members from having to incur out of pocket medical expenses, while many of those in formal employment are enrolled on medical insurance schemes by their employers.
Cost is one of the barriers to accessing health care in Uganda; hence proponents of the National Health Insurance Scheme (NHIS) contend that, provided it is well designed and implemented, it will be a significant step in the right direction in terms of addressing this barrier and increasing the number of people able to access quality health care. This article critically analyses Uganda’s proposed National Health Insurance Bill 2012 which is to operationalize the NHIS.

Background
Uganda is a state party to a number of regional and international human rights instruments that enshrine the right to the highest attainable standard of physical and mental health (herein referred to as the right to health). Article 25 of the Universal Declaration on Human Rights provides that every person has a right to a standard of living adequate for their health and well-being. Article 12 (1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) states that States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Other provisions include Article 52 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, Articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979, and Article 24 of the Convention on the Rights of the Child of 1989.

At the regional level, Article 16 of the African Charter on Human and Peoples’ Rights of 1981 is to the effect that every individual shall have the right to enjoy the best attainable state of physical and mental health, and State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

In the domestic setting, although there is no substantive right to health under Uganda’s Bill of Rights, the Constitution provides for several rights that are determinants of health. Article 33 (3)
provides that ‘[t]he State shall protect women and their rights, taking into account their...maternal functions’; Article 34 (3) states that ‘[n]o child shall be deprived by any person of medical treatent...by reason of religious or other beliefs’ and Article 39 provides for the right to a clean and healthy environment.

Direct provisions on health are found under the National Objectives and Directive Principles of State Policy (NODPSP) in the Preamble to the Constitution. These NODPSP have a binding effect in light of Article 8A which states that Uganda shall be governed based on principles set out in the NODPSP. Objective XIV (b) inter alia enjoins the State to ensure that all Ugandans enjoy access to health services, while objective XX provides that the State shall take all practical measures to ensure the provision of basic medical services to the population. Objectives XXI and XXII provide for clean and safe water, and food security and nutrition respectively, both of which are determinants of health.

The nature of the right to health requires active State intervention, and the State is not only legally responsible for violating or infringing the rights of individuals with its activities, but also for those violations that occur because it has not acted in the expected manner.

There are other Government mechanisms geared towards the achievement and attainment of health for all Ugandans; the National Development Plan\(^2\) seeks to address the constraints that hinder access to medical treatment and services by making provision for universal access to a quality Uganda Minimum Healthcare Package, which prioritizes the needs of vulnerable populations; Uganda Vision 2040,\(^3\) sets out strategic priorities that public-private partnerships can bring to fruition – an example of which is the proposed universal health insurance scheme.

\(^2\) National Development Plan (2010/11- 2014/2015); chapter 7: Social Sectors, 246
\(^3\) Uganda Vision 2040; chapter 5: Social Transformation – Health and Nutrition, 88

Women from Bbaale Sub-County in Kayunga district discuss health service delivery challenges at a community dialogue convened by ISER on 28th April 2015

Getting it Right: Uganda’s Proposed National Health Insurance Scheme
The right to health, like all human rights, imposes on State Parties three types of obligations: namely, the obligation to respect, protect and fulfill the human right in question. Fulfillment implies taking positive steps to realize the right to health which may include, adopting appropriate legislation and policies, undertaking legal reforms, adopting pro-health budgetary measures and the like. The proposed National Health Insurance Bill (NHIB) 2012 is one measure by means of which the Ugandan government seeks to fulfill its obligation to provide citizen’s with their right to health.

A Critique of the National Health Insurance Bill and Recommendations

The initiative to enact the NHIB and the attendant Policy to promote universal health coverage for all Ugandans and ensure access to health care is a highly commendable effort by the State and all other stakeholders who have participated in its development. The broad objective of the NHIB is to provide for the establishment of the National Health Insurance Scheme (NHIS) and its functions; accordingly, it enables among other things the establishment of the Scheme’s Board, outlining its composition, functions and powers; provide for staffing and funding; registration of contributors and their beneficiaries; the articulation of benefits available under the scheme; the creation of an accreditation committee to review prospective health care contractors and their service and payment agreements; regional health insurance offices; and an Appeals tribunal to hear disputes arising from the implementation of the Bill.  

In spite of its positive intentions, the NHIB falls short in a number of important respects as spelt out below.

a) Definition of children to be covered

Clause 3 of the interpretation section of NHIB defines a child as a biological or lawfully adopted son or daughter of a contributor who is below 18 years (or wholly dependent on the contributor if older than 18 years). This clause seems to ignore the African context where families are largely extended in nature and usually include children of other relatives (that may be dead or unable to take care of the children effectively) who may not necessarily be adopted but are rather under guardianship de jure or de facto, in foster care or placement. The formulation of this section will exclude from coverage children under mere guardianship or foster care placement – who constitute a significant proportion of dependants in Uganda’s extended family context.

b) Number of dependants to be registered

Clause 5(2) of NHIB provides that a member of the NHIS may register up to a maximum of four dependents as beneficiaries of the scheme. Again, this is an unrealistic limitation in the Ugandan context, where the average number of children born to a woman is six (6) according to UNICEF 2012 statistics. The scheme’s restriction of dependents to four means that some children would not be covered and thus able to access healthcare under the scheme, which is contrary to its stipulated aim of increasing access to health care.

---

4. See the Long Title to the NHIB. Also see 5 (2) of the NHIB stipulating the main objective of the Bill to include: Facilitating provision of accessible, affordable, acceptable and quality healthcare services to all residents irrespective of their age, or economic or health or social status; To develop health insurance as a complementary mechanism of healthcare financing in Uganda; To ensure efficiency in the health care services; To avail good quality accessible, equitable and affordable health care for all residents; To ensure equitable distribution of costs among different income groups; To maintain a high standard of delivery services in Uganda among others.

5. Adoption under Section 56 of the Children Act Cap 59 is the legal process by which a person becomes the adoptive parent of a child and the adoption order granted by the High Court extinguishes and terminates the rights, duties and liabilities of the biological parents of the child.

6. Guardianship, foster care or placement grant an adult person parental responsibility of a child without extinguishing the rights and duties of the biological parents. www.unicef.org/infobycountry/uganda_statistics.html, (accessed on 7th April, 2015)
In contrast, Kenya's NHIS does not impose a numerical limit on the number of dependants who may be registered by scheme members; it provides, instead for coverage of the primary policy holder's dependants, that is their spouse, children under the age of eighteen (18), students (who may be older than 18 but no older than 25-years) and persons with disabilities who are dependents of the primary policy holder.7 We recommend that Uganda adopts this approach, so that the number of dependents is not prescribed and restricted; in this way, the determination depends on the primary member disclosing those related to/in close affinity to them, and paying their pro-rata subscription.

c) Defining Indigent person
Under Clause 9 of the Bill, a person who is not eligible for membership to the scheme either as a public servant, National Social Security Fund (NSSF) contributor or a Community Health Scheme (CHIS), shall be regarded an indigent.8 This is a very broad and indeterminate definition, which may lead to serious problems as it does not provide substantive criteria by means of which to identify indigence. One unintended but possible consequence of this oversight is that a wealthy individual who is neither employed nor contributes to NSSF or a CHIS could be deemed indigent and thus eligible for State subsidization of their NHIS subscription. We recommend that a clearer definition of indigent persons be provided in the Bill to avoid manipulation of such loopholes by opportunistic and responsibility-shirking members of society.

d) Contributions to the scheme
Clause 11(1a& b) of the Bill requires public servants and employees already contributing to a pension or NSSF scheme to direct 4% of their salaries/contributions to the NHIS. We contend that this proposition is unfair as it imposes a strain on the already meager salaries of members. The case of Ghana is instructive as the country also has a Social Security and National Insurance Fund, (the equivalent of Uganda's NSSF); however, Ghana, requires only 2.5% of each person's contribution to the Social Security and National Insurance Fund to be directed towards one's medical insurance so as to avoid double deduction.

It is recommended that Uganda adopts Ghana's approach in this regard: instead of a double deduction on the salaries of public servants and other registered members of the NSSF. The deduction should be drawn from the percentage contributed to the pension scheme and NSSF contributions monthly.

e) People in the informal sector
The Bill does not make clear provision for people working in the informal sector. The Bill presumes that the informal sector implies and includes all members who are not public servants, members of the NSSF or indigent persons. It may be argued that Clause 8, which provides for CHIS, covers informal-sector people. However, this is not certain. Consequently, the Bill's conceptualization of informal sector members is vague and ambiguous. It is important to make adequate provision for the informal sector as a significant proportion of Uganda’s economy is dependent on the informal sector: The World Bank has reported that the informal sector employs about 90% of the total non-farm private workers in Uganda.9

For this reason, we contend that the Bill should have a clear and express provision on informal sector members. Uganda could borrow from Kenya’s NHIS: section 16(1)10 of its enabling Act provides that where people in the informal sector or who are self-employed have a determined amount of money,

7 S.15 of the National Health Insurance Fund Act of Kenya, supra.
8 Section 5 & 8 on membership to the NHIS and Community health Insurance scheme respectively
9 S. 41 of the National Health Insurance Act of Ghana, supra.
10 Urban Informal Sector in Uganda, A paper presented at The Key Labour Market Issues Course, April/May 2005, at p.1
11 S.16(1) of the National Hospital Insurance Fund Act, No. 9 of 1998.
f) The efficacy of the proposed Community Health Insurance Schemes (CHIS)

Clause 6(k) of the NHIB makes provision for the establishment of Community Health Insurance Schemes (CHIS) which are intended to cover persons who do not qualify as members of the NHIS by virtue of not being either public servants or employees making NSSF contributions. Clause 8 provides that whoever is not a beneficiary of the NHIS under clause 5 shall be registered under the CHIS. However, the clause has a number of deficiencies: it does not provide any details on how the CHIS are going to be organized, their mode of operation and generally how they shall be incorporated into the NHIB. Lessons relating to the modes of functioning, membership criteria and benefits, challenges, etc. should be drawn from Uganda’s existing CHIS. A few examples of CHIS in Uganda include, eQuality at Bwindi Community Hospital in Kanungu district, Nyakibale Health Plan at Nyakibale Hospital in Rukungiri district, Ishaka health plan in Bushenyi district, Happy health insurance scheme in Ntungamo district, Save for health Uganda schemes in Sheema, Mubende and Masaka districts, Shine Africa Ministries in Soroti district.

Furthermore, Uganda should borrow a leaf from the experience of Ghana and Rwanda since these countries have been running CHIS alongside their NHIS. In Ghana, the hub of the health care system is the National Health Insurance Fund. The satellites are a country wide network of CHIS known as District Wide Mutual Health Insurance (DWHI) schemes which are monitored, subsidized and re-insured by the hub – the role of Government is not to manage the funds of the CBHIs. In Rwanda, CHIS were a partnership between communities and health centers before their transformation into a state-community partnership. In 2004, a policy of a flat rate of household contributions to CHIS was adopted to ensure that cost is not a barrier to access to health facilities. The Government tops up the contributions made by the subscribers of CHIS to enable access to health care services.

An example of a Community Health Insurance Scheme in Rukungiri District

---

12 s.15 (1) (b) (c)
13 Clause 8
14 http://ucbhfa.org/membership/chis-schemes/
16 Rwanda National Health Insurance Policy 2010
g) Other vulnerable groups

I. Pensioners and unemployed persons

It is a primary objective of the NHIB to provide affordable, accessible, acceptable and quality health services to all residents irrespective of their economic or social status. In spite of this laudable move, the Bill overlooks the status of pensioners (or otherwise retired from service) and unemployed persons. There is no clear provision that seeks to ensure health insurance coverage for this category of person, who are generally socially and economically vulnerable members of society. Ghana, on the other hand, expressly exempts pensioners from having to make contributions to the NHIS Fund. Uganda should similarly clarify the status of pensioners with respect to NHIS contributions.

II. People with Disabilities and Elderly persons

It is further proposed that the Bill should grant a special vulnerability status to persons with disabilities (PWDs) and elderly persons in their own right or as persons who are dependent on the primary policy holder depending on their circumstances. In Kenya, s.15 of its NHIS enabling Act recognises persons with disabilities as dependents of the primary policy holder. In Ghana, persons aged 70 years and above are exempted from making contribution to the NHIS fund; but this does not disqualify them from enjoying its benefits and accessing health care services.

The analysis above has brought to the fore the glaring gaps in Uganda's NHIS as currently conceived. It is evident, therefore, that there is still need to revisit the NHIB. It is hoped that government will take seriously the recommendations preferred in this article, which seek to further government's own objective of achieving universal health coverage for all Ugandans.

Conclusion

The NHIB is no doubt a huge step in the right direction for Uganda to consolidate the gains made thus far in respect of the realisation of the right to health for all Ugandans as stipulated in international, regional and national legal/policy frameworks. However, in order to more effectively and meaningfully realize the noble aspirations of the NHIB, government should seriously address the gaps in the Bill identified and discussed above. Government should also draw liberally on lessons from regional counterparts, namely, Kenya, Ghana and Rwanda. It should be noted, however, that the law alone – no matter how soundly it is formulated – cannot effect meaningful transformation without the political will to address the challenges that affect the realisation of the right to universal health care.

18 Section 2(1a)
19 S.29 Ibid.
20 S.15 of the National Hospital Insurance Fund, supra.
Furthermore, it is imperative to guarantee and safeguard the independence of the NHIS board, to ensure that it’s operations remain free from political interference and corruption. Care should be taken to ensure that the composition of the board, while diverse, retains expertise in the area of health and insurance law in order to ensure competence and effective management of the scheme. The present Bill makes no mention of a representative from the Ministry of Justice and Constitutional Affairs, specifically a lawyer, whose presence would be vital in ensuring that activities carried out by the board are in compliance with international and national benchmarks. It would be productive to have board members with professional medical and labor skills. In the case of Ghana, the board consists of specialized doctors, a pharmacist, legal practitioners with expertise in health insurance, and an organized labor representation.

The shortage in health sector personnel should be averted by training more health workers to enable the smooth running of the Scheme. Current statistics suggest that there is one doctor for every 7,272 Ugandans. The World Bank’s statistics reveal an even dimmer outlook with a ratio of 1.8 health workers per 1,000 people. Training and improving the skills of health workers to meet the needs of a large patient population would go a long way to ensuring that health resources are adequately used to provide equitably for the populace in accordance with the objectives of the NHIB and upholding the Constitution.

---

21 Section 13 provided that members of the Board of Directors of the NHIS shall consist of.
22 § 4 national health insurance act 2012

nal-health-but-serious-challenges-remain, accessed on 2nd April, 2015.
Uganda cannot wait for all of the challenges surrounding the proposed National Health Insurance Scheme (NHIS) to be resolved before rolling out the ambitious programme, Dr. Francis Runumi, the chairperson of the national task force, has said. In an exclusive interview, Dr. Runumi, who also serves as the Commissioner for Planning at the Ministry of Health, said that in all of the countries where the scheme is regarded successful, the programmes were initially mired in controversy and did not get off to a perfect start.

Dr. Runumi is confident that Uganda will avoid the pitfalls associated with implementing the NHIS because the task force identified sufficient lessons from several countries that have successfully implemented a national health insurance including Ghana, Kenya, Nigeria, Rwanda, Tanzania and Thailand among others. He noted that these lessons have informed the design of the scheme and the proposed law regulating it. “Other countries have advised us that in order to learn to swim, it is best to jump into the swimming pool – you cannot do so on dry land. So they are encouraging us to jump into the water and to sort ourselves out as people start benefiting from the insurance scheme,” he stated.

Dr. Runumi explained that the reason the scheme had not taken off since the idea was mooted over 10 years ago is because of the advice Uganda received from these countries, which urged the ministry to hold extensive consultations so that once implementation commenced, it would be accepted, well understood and supported by all relevant stakeholder including key role-players in the health sector. “The Thai government informed us that it took 25 years (from 1948 to 1974) for their NHIS Bill to be tabled before parliament. However, when the Bill was finally passed into law, they did not regret the time that elapsed because it allowed for extensive consultation and awareness raising as well as refinement of the scheme’s design.” He added that “even with us, when we started there was significant resistance to this idea; Now I am glad to observe that the support for the proposal is higher than I had anticipated it would be; and this has been achieved within a relatively short time. People do realize that without health insurance we all run a terrible risk,” he added.

Dr. Runumi noted that the Ministry of Health is now waiting for a certificate of financial implication from the Ministry of Finance so that the draft NHIS Bill can be presented to Parliament for enactment. He explained that all of the queries regarding the scheme, which were raised by the Ministry of Finance, have been addressed; hence the Health Ministry’s optimism that the certificate will be issued soon. “The Ministry of Finance sought clarity regarding the operation of the scheme – for example, the modes of contribution and collection, allocation and accountability to ensure that all contributors benefit from the scheme. We responded to these questions in October.
2014. Since that time we have been waiting for the certificate and we believe that we will receive a positive response soon, which will enable us to proceed,” he said.

Asking if whether the current poor state of health facilities in the country may not discourage people from subscribing to the scheme, Dr. Runumi stated that while the argument may at first appear to be valid, it was a chicken and egg argument because the more people subscribe the more resources the Health Ministry will have to improve and expand on existing health facilities.

He said the scheme would even incentivize private investors who have to date been skeptical to invest heavily in health services, particularly in rural areas, to do so because returns on their investments would be assured through payouts from the scheme. Dr. Runumi further stated, “why don’t we have adequate, functional infrastructure? Why don’t we have adequate human resource? Basically it’s because the money has not been there. The revenue generated through NHIS subscriptions will stimulate the creation of this infrastructure, especially in the private sector.”

Studies have revealed that employees currently spend up to 22% of their income on healthcare. However, under the proposed scheme, both the employer and employee would be expected to contribute 4% towards the scheme. In the light of the envisaged contribution of employers to the scheme, there have been concerns from certain quarters that the perceived increase in the cost of doing business in the country may discourage prospective foreign direct investment into Uganda.

Suggestions have also been made that since formally employed persons already contribute towards social security, a percentage of this monthly contribution could be diverted to the health insurance scheme to avoid an excessive burden on employers and employees who constitute the largest group of tax payers in the country. Dr. Runumi is of the opinion that health is a critical part of social security and that the insurance scheme should ideally have been run by the National Social Security Fund (NSSF). “All the money under NSSF, if it’s for social security, they could allow a portion of contributions to be dedicated towards the health component. In other words NSSF would ring-fence a proportion of funds for use by the NHIS. So negotiations are now between worker’s unions and NSSF.”

“The key concern cited in all the consultations we convened related to how these huge sums of NHIS money will be processed and safeguarded. We asked the same questions in the countries in which we conducted bench-marking studies and they showed us the methods and systems they have developed that really can significantly reduce any element of fraud,” he observed. We were shown different systems, methods and software packages that have been developed to ensure accountable revenue collection and spending – some of which have been proven to reduce fraud by up to 95%”, he concluded.
Introduction
According to a recent poll conducted by the International Republican Institute (IRI), 61% of people interviewed believe that the Ugandan government has been successful in improving basic health services. The poll results also reveal that more than 50% of respondents thought that since the 2011 elections, the quality and expansion of infrastructure and human resources in government hospitals and health clinics either remained stagnant or worsened, peaking to 68% of respondents who regard Uganda's health-care costs as unreasonably high. It appears that the National Health Insurance Scheme (NHIS), which the Government of Uganda (GOU) is proposing to launch this year, is opportune. However, given that the NHIS project commenced over thirteen years ago and is still awaiting the Ministry of Finance's approval by means of the issuance of a certificate of financial implication, it is unlikely that Uganda's NHIS will become operative in 2015. In the light of repeated calls for reforms to Uganda’s health system, and whilst awaiting the scheme's approval, it is an ideal time to evaluate the NHIS, as currently conceived, to identify potential weaknesses and propose ways of addressing these to ensure a successful health-care insurance scheme once it is ultimately implemented.

On the scheme’s implementation
It is envisaged that the NHIS will be rolled out incrementally: it will be introduced to civil servants first and formal sector workers. Informal sector workers, representing 73.5% of Uganda’s workforce, and indigent persons would be incorporated later into the scheme. There are no clear timelines of when to include the latter comprising of the unemployed and vulnerable groups like the elderly and orphaned children. There might be a significant lag if the integration of informally employed and indigent persons is contingent upon the scheme’s sustainability/profitability. Ironically, it is those most in need of this health insurance who will benefit from it last, and who as a result will be compelled to spend considerable proportions of their income to cover out-of-pocket expenses (OOP). It is estimated that the average OOP health expenditure as a percentage of total expenditure by Ugandans on health between 2005 and 2012 represented 50.7% (the equivalent of US$19,57), 30% more than is spent by Rwandans for instance, as shown in Chart 1 below.

"Ironically, it is those most in need of this health insurance who will benefit from it last..."

1 Museveni fail on poverty, democracy, corruption, The Independent, Issue N°361 March 27 – April 02, 2015, pp. 12-13
On the NHIS financing

According to Dr. Kenneth Omona, Chairperson of the Committee on Health in Parliament, the projected financing of the scheme is as follows: employees will contribute to the NHIS 4% of their gross monthly earnings, a sum to be matched by employers in respect of all contributing employees. With the formally employed representing roughly 25% of the workforce in Uganda\(^6\) the revenues raised from their contributions is insufficient to sustain the scheme to a profitable level. Furthermore, since it is intended that civil servants will be the first to be integrated into the NHIS, their contributions imply represent a reallocation of the government's budget towards the NHIS because their salaries are budgeted and paid by government. The implication of this NHIS contribution from the government's budget would potentially reduce public budget resources available for the poor, and impact negatively on the funding of public health care and facilities for those not yet included in the scheme.\(^7\)

On good practices during the elaboration of the NHIS

Inclusiveness

The Committee on Health responsible for the structuring of the NHIS has opted for an inclusive approach to health insurance, gathering healthcare professionals, and private insurers alike to the negotiating table. Despite being invited, the National Social Security Fund (NSSF) declined to join the panel of the National Task Force created by the Ministry of Health.\(^8\) The influence of stakeholders on the NHIS has thus remained limited and has not significantly altered the plan proposed by the GOU.

---


\(^7\) Dr Michael Adelhardt et al: The proposed National Health Insurance Scheme and promotion of Social Health Protection in Uganda. ILO, Providing for Health (P4H), March 2010. P30

\(^8\) Ibid. p27
The Committee in charge of the NHIS did observe several national health insurance programmes in other countries, including Kenya and Israel. The Committee flew to Israel in late 2014 to draw on the successful Israeli health insurance model and to look into the potential to create strategic partnerships.9

While there is no doubt about the success and efficiency of Israel’s health scheme, conditions in the two countries are very different, not only from a social but also an economic point of view, with Israel having a clear advantage with respect to its capacity to finance its NHIS programme in the long run. This does raise questions regarding the selection by the GOU of Israel as a best practice cases study. It would have been far more beneficial for the GOU to consult a system implemented in a country with a similar environment to Uganda – such as Rwanda, for example, whose government has enjoyed relative success with its Mutuelle de Santé (Health Insurance). Rwanda’s system has been very efficient in including a broad cross-section and virtually the entirety of its population into the insurance scheme.10

Having similar economies, it would have been sound to draw on the Rwandan structure, which by 2010 had enrolled 8.5 million members.11 The Mutuelle de Santé is, to a great extent, supported by aid. Given that the GOU will struggle to finance its own scheme, it could consider using aid to that end, or reattribute revenues from taxes on certain goods, for instance on alcohol and cigarette sales, towards financing the scheme. Such financing could facilitate the incorporation of the informal sector and the poor from the NHIS’s inception as opposed to having two parallel health-care systems, namely the NHIS and public health services, both supported by government revenues until such stage as the NHIS’s membership is expanded to the informal sector and indigents. This would allow for financing to be directed solely towards the NHIS and the resources – material and human – committed to supporting the scheme, in so doing freeing up resources to improve poor existing infrastructure, increase and enhance human resources, and offer more competitive wages to discourage and reduce high absenteeism rates currently observed among health workers12 in rural areas.

There is a clear discrepancy between the urban and rural health infrastructures and human resources found in Uganda, which puts the latter at a significant disadvantage in terms of capacity to provide for health services. This imbalance has not been addressed during the elaboration of the NHIS; and unfortunately, the absence of an operational apparatus diminishes the NHIS – an oversight it is hoped the GOU will rectify at the earliest opportunity to avoid making the scheme redundant. While this problem is not the most expensive to solve, the Finance Ministry’s refusal to increase the health sector budget prevents genuine improvements in service delivery. In low-income countries such as Uganda, improvements to service delivery depend on support-led process and the relative costs of infrastructures and labour intensive resources in contrast to costs incurred in developed countries. The relative cost of improving health service capacity should be taken into account in the budgeting of the NHIS, for both are inherently intertwined. It is regrettable that the marginal increase in Health budget thus far has prevented any real improvements to work conditions in public health facilities, which precludes improvements to the quality of care received by patients.

Conclusions
There is no doubt that the World Health Organisation (WHO) would welcome the implementation of the NHIS, as it recommends universal health coverage in Sub-Saharan African countries. If, however, the scheme fails to insure all Ugandans from inception without guarantees of success in the long term on account of its limited capacity to generate revenues from affiliated workers, then an NHIS may not be perceived as the most appealing universal health care scheme by Ugandans who might fear that the most in need will be left behind. If the GOU nourishes the ambition to ultimately have a public health care system as efficient and effective as Israel, then the NHIS must be designed in such a way that it confronts the challenges specific to Uganda. It would have been preferable for Uganda to look to a more contextually appropriate country to study for lessons on how to establish a successful, inclusive NHIS system in a low-income country. One possible outcome would have been a sliding scale of contributions calculated according to member’s incomes such that wealthier members fill the financing gap of poorer members. Finally, the GOU needs to address infrastructure deficit to increase the success prospects of the NHIS, since the scheme is only relevant if there are accessible facilities all around the country, and sufficient staff and medication supply to provide care to the patients.

Question: What’s the case for National health Insurance? Why do we need it as a country?

Answer: We need to establish a fair way of getting citizens to contribute to their health without torturing them, which is what is happening at the moment: people obtain medical treatment through out of pocket expenses, even in emergency situations. Government would like to see this change to a more equitable situation so that people make regular contributions to a fund that can cover their treatment when sick (because every time you become sick you may not have money at that moment) and also help the poor who could otherwise not afford healthcare. So this is the concept of health insurance: you make small contributions to a fund and when you are sick you can go to a health facility to seek treatment and not incur the full bill as you would presently.

Question: It’s been over a decade since the idea of a national health insurance scheme was first proposed, why has it taken so long for the Bill to be formulated?

Answer: There are many stakeholders involved in the creation of a health fund, whom government has sought to consult and bring on board to make sure that the process unfolds smoothly as we move from a public health care system, which has as matter of policy been a free service, to a more inclusive system that involves private healthcare providers. Now we want to proceed with implementation so that we can make modifications to the health insurance scheme as and where necessary based on feedback from beneficiaries, whom government may not have consulted as extensively as service-providers.

Question: There are still some groups that say their views have not been sought? One such is Kampala City Traders Association (KACITA), whose leadership claims it has not been consulted on the proposed NHIS.

Answer: I don’t know whether KACITA was around when this process started ten years ago. But you see that’s the problem of prolonging processes: even someone who was born yesterday will say I was not consulted. But many trade organizations, including the National Chamber of Commerce and so on, have been consulted by our technical team. But having said that, now that we have a new institution called KACITA, we have an obligation to consult them; but what we are saying is that this should not delay implementation – consultations can continue even as we roll out NHIS. This can help us to
identify any emerging issues or challenges that need our attention and may require strategic resolution. But we have taken note and I will talk to our technical team to make sure KACITA is brought on board.

**Question:** You are talking about the need to start; we know the Bill regulating the scheme has already been drafted, so what’s holding you up?

**Answer:** There are financial implications: we need to budget for the capital required to create and operationalize the agency that will administer the health insurance scheme. The Ministry of Finance will obviously have to review government revenues to assess where to derive these funds. On our part, we have submitted to the Ministry of Finance the information it required to undertake an economic analysis and issue the certificate of financial implication once it has arrived at a favorable decision. Naturally this takes time, because the Finance Ministry must review our proposal in the context of the economic picture of the country. We may need about 500 billion to kick start the process, so Finance has to weigh up the social benefit of such a huge investment and then identify all possible ways in which this money can be mobilized so this is a long process and they have to consult as well before they can prescribe the best option.

**Question:** This scheme is initially targeting civil servants and other formally employed Ugandans, the bulk of whom are already subscribed to private health insurance. What is the rationale for compelling these people to contribute to NHIS?

**Answer:** Those public servants are the same people who come to public health institutions seeking referrals to India and you ask them, “but you have a subscription to a private insurance scheme – why is it not providing you with adequate health care facilities and services here in Uganda?” While private insurance schemes may not invest in development because their outlook is simply to make profits, a strategic partnership with government on NHIS will be mutually beneficial and in the long run prevent referrals abroad. Funds generated from subscribers will be used to improve our health care facilities and services.

**Question:** Is our health infrastructure able to handle the demands for services that may arise as a result of this scheme?

**Answer:** Many health care problems and challenges in Uganda are attributable to gaps in health financing: we are unable to improve existing healthcare facilities, or invest in new ones, or increase the number of healthcare workers or expand the reach of our services into remote and rural areas because of a lack of resource. So we are saying let’s collect money from stakeholders through an insurance mechanism so that we can improve these services and infrastructure and provide affordable, quality healthcare for all Ugandans.

**Question:** Another issue that has been raised relates to the recommendation that contribution to the scheme, especially for employed Ugandans, should be made through deductions from NSSF social security contributions. Workers are saying their incomes are low and they already pay taxes and NSSF contributions. What is your view on this matter?
Answer: I think this is a question of sensitization – we need people to understand why their income is stretched. It’s because their expenditure on health services is so high. Take government employees for example, if they receive housing, a vehicle, school fees allowances, then why would they still need a big salary?

Question: What about employers? They say even in countries where national health insurance has been perfected contributions are made by individuals and the central government. You are asking them to contribute 4%, are you not raising the cost of doing business in the country?

Answer: Yes it is true that prioritizing investment in health insurance shifts the economic equilibrium of a country; but it does so positively. The standard of living in Uganda is not like it was in the 1970's. This is because of economic advances. But even so, the standard of living in Uganda is not on par with the UK for example: employers need to contribute towards health insurance because they benefit from a healthy workforce; moreover, children and disadvantaged youth are their potential future employees. Those children whom we want to prevent from dying unnecessarily from preventable diseases such as measles, mumps, malaria, etc. are our future engineers – some may be even geniuses. So in the long term employers will appreciate that we are making the population healthy and we are providing a very healthy pool of employees who will contribute to innovation, creativity, capacity; that’s how economies grow.

Question: What percentage does governments intend to commit to this scheme?

Answer: Government has to contribute, especially towards the startup capital. Over time, the scheme will become self-sustaining. Government will also generally contribute for disadvantaged communities.

Question: Your final word to Ugandans regarding this scheme.

Answer: Commentators on the proposed scheme have referred to similar initiatives in other countries. When you listen to radio they say in Rwanda it works, in Tanzania it has done this. Now what everybody has seen working in Rwanda, Tanzania or in Ghana is what we want to bring to Uganda. People are still fearful and want to benefit from a free service. Free service is possible to some extent; but we are a population of around 35-40 million and government cannot sustain a high quality of health care for all Ugandans without their contributions and support. So people should cooperate with government. If we are to successfully implement an affordable, quality health care system, lets support implementation of NHIS and then we can look at the emerging challenges and address them.
Members of Parliament (MPs) have weighed in on the proposed National Health Insurance Scheme (NHIS) saying it is long overdue. The MPs, the majority of whom are from the health committee of Parliament, feel that the NHIS is a very good proposal that should be fast tracked as it will eliminate out of pocket spending for many Ugandans and improve access to better health services for more people. By virtue of being on the health committee, some MPs have attended workshops, retreats and other platforms to discuss the proposed scheme. Some have also participated in the benchmarking visit to Israel.

Dr. Kenneth Omona, Kaberamaido County MP and Chairperson, Health Committee of Parliament said the progress on the proposed National Health Insurance Scheme Bill is moving on square wheels. “We need it like yesterday. Many people are desperate and to me we have delayed.” “It has been long overdue and we have moved more in reverse,” said Kalungu West MP Hon. Joseph Gonzaga Ssewungu. Dr. Medard Bitekyerezo, Mbarara Municipality MP and a member of the health committee noted that what Ugandans need is the will and commitment from government. “We can start small and improve but people do not want to start. “Let us improve our health facilities and the human resources for health and not get cleaners to run health centres. We should disregard sending doctors to Trinidad and Tobago because we have no doctors.

We should send consultants to the district hospitals like surgeons and gynecologists.” He added that the Ministry of Finance has delayed to issue the certificate of financial implication but hopes that the new minister of Finance Hon. Matia Kasaija will fast track the process. Rwampara County MP Hon. Kyamadidi Vincent noted that the current public health care system is capable of meeting the objectives of the scheme if the government prioritizes the health sector. About financing for the scheme, the legislator proposed “a ratio of two to one meaning that if government contributes ten percent, service users should contribute five percent.” To ensure efficient service delivery in rural areas, Hon Kyamadidi advises that Health Centre IIIIs should be well equipped with medical equipment and qualified health personnel.

Dr. Medard Bitekyerezo advised that to make sure the informal sector is effectively included in the scheme, “every Ugandan should have an identity card so that we know who to cater for, and
so that government commits enough resources. The unemployed
should be insured in government institutions and this can be
managed if everyone has an identity card.” Hon. Kyamadidi
acknowledged that most people work in the informal sector
with the result that information on their earnings is not clear. He
emphasized the need to sensitize people to the value of the
scheme and to peg it to the national identification system. Kabale
Woman MP Hon. Rhona Ninsiima too called for the
sensitization of people in the informal sector to the benefits
of joining the scheme and to communicate to them the best
practices of NHIS implemented elsewhere. Hon. Omona
re-echoed his colleagues’ sentiments and called for the
government to carry out public education to create awareness
about the scheme, especially among the informal sector to
courage them to effectively come on board.

Addressing concerns of oversight and accountability, Dr. Omana
singled this out as the biggest risk to the success of a national
health scheme. “Those few who have saved with NSSF, convincing them about insurance is a big task.
[With NSSF] some die without benefitting and others spend a lot to access their money. Performance
of NSSF is one impediment to the acceptance of the scheme. Many who have interacted with NSSF
have a lot of reservations regarding social security”.

Hon. Kyamadidi was of the view that the scheme can be implemented successfully provided it is well
designed, has an institutional framework and extensive consultation is conducted bringing on board
multi-stakeholders to contribute towards a scheme that meets global best practice standards.

It is clear from the discussion that the MPs are in support of the NHIS, which is why
they provided vital suggestions on how to successfully implement the scheme. They
underscored the need for wider consultations as many Ugandans, including a good number of MPs,
do not have all of the relevant information on the proposed scheme and its enforcing Bill; MPs also
identified the need to learn from other African countries that are already implementing the scheme.
On October 4, 2007, David Chandi Jamwa, the Managing Director of National Social Security Fund (NSSF) at the time, invited the media to attend a hastily convened press briefing. The meeting, which was held in his 14th floor office at Workers’ House, was called to discuss an earlier NSSF board meeting. In his customary brash manner, he stated, “The NSSF [board] has agreed to propose a Health Insurance Scheme for its members … [in line with developments] around the world and in accordance with the International Labour Organisation standards [which call for] mandatory social security schemes [to] provide medical coverage”. Jamwa added that the scheme, which was awaiting approval by the Ministry of Finance, Planning and Economic Planning, would target the fund’s 500,000 contributors, as part of a “value addition” strategy. “The NSSF is considering increasing its product base by providing health insurance to members financed by their existing contributions to the fund.” To avoid any contradiction, Jamwa continued, “NSSF is opposed to the proposed National Social Health Insurance Scheme [NHIS]”.

The Health Ministry was then intending to target as core NHIS members; the same 500,000 people in formal employment that Jamwa now saw as NSSF’s responsibility. Jamwa felt that an NSSF funded health scheme would offer more value for money than a scheme of the parastatal Uganda National
Social Health Insurance Corporation, which was to be established to run the NHIS. He later told The Observer in a July 30, 2008 interview, that his decision was informed by plans by the Ministry of Finance to liberalise the pension sector and allow the NSSF to compete with other players. “For us at the NSSF, we are very excited about this development. One advantage is that there will be a specified regulator—bringing in expertise, guidance, oversight and obviously discipline within the market,” Jamwa said at the time. “Medical Insurance is one of the products we are working on and intend to implement before the end of this quarter. We think we will be able to offer free medical coverage for a member, spouse and two children. And we are not asking for any more money from contributors. We are also looking at an HIV-AIDS product.”

Disagreements
But if Jamwa was expecting opposition from the Health Ministry, he got it and much more. Dr Francis Runumi, a Commissioner in the Ministry of Health, who was chairing the taskforce to establish the NHIS, argued that the Ministry of Health offered the best proposal for Ugandans. But Jamwa soon found allies in the Federation of Uganda Employers, whose Chairman, Aloysius Ssemmanda, complained that the NHIS framework was not well thought through. “We are not opposed to social health insurance and social security. What we are against is the structure of the proposed scheme and the speed at which it is being undertaken,” Ssemmanda argued.

Later discussions on the matter by employers continue to favour Jamwa’s initial proposal. A meeting of private companies, organised by the Private Sector Foundation of Uganda and held in Lugogo in March, saw several Chief Executives indicate that they would be happy to provide health insurance to their employees through the NSSF. The former Uganda Manufacturers Association Chairman, Hajji Kaddu Kiberu, was one of these proponents. “If the legal framework was well laid out, I’m sure the NSSF would be able to find a more affordable way of delivering health insurance at a lower cost than anyone [else],” said Kiberu. Many also complained about the lack of consultation when the NHIS was being proposed. In response, Dr. Runumi argued that the government had conducted extensive consultations on the scheme. He added that Uganda’s framework borrowed liberally from that of Tanzania. “We intend to borrow a leaf from our neighbours in Tanzania, who started off by covering those in the formal sector, before rolling it out to the rest of the public,” Dr. Runumi said.

Tanzania’s National Health Insurance Fund, started in 1999, owes its origins to a 1967 decree by President Julius Nyerere banning private medical practice and thereby ushering in free and universal health care for Tanzanians. However, owing to the escalating costs of health care, Tanzania introduced the NHIF in 1999, which initially covered public servants. In 2003, the NHIF Act was amended to allow for private membership, thus incorporating those in the private sector who sought to acquire medical insurance through the fund. However, health insurance remains low in Tanzania, with the NHIF covering around 6% of the population.
Current situation

Despite the disagreements, Dr Runumi and Jamwa’s successor, Richard Byarugaba are yet to make any headway in establishing a national health scheme for Ugandans. Dr. Runumi’s proposals were incorporated into the revised National Health Insurance Bill of 2012. Dr. Runumi seems resigned to waiting until 2016 for the Bill to be tabled before Parliament.

In October 2014, Dr. Runumi was appointed to the board of the Insurance Regulatory Authority (IRA), and at the time stated that his task would be to promote health insurance in the sector. IRA’s Chief Executive Officer, Hajji Ibrahim Kaddunabi Lubega, says they are waiting for the outcome of deliberations by cabinet on the matter. “We appreciate that universal health insurance is pivotal to the provision of quality and affordable healthcare in Uganda. For now we can only persuade more of the insurance players to take it up, until a new legal framework presents solutions to some of the challenges faced by industry players,” he said.

For his part, Byarugaba says proposals for a health scheme were approved by the former Finance Minister, Maria Kiwanuka; however, these cannot be implemented until the NSSF Act is amended to reflect a liberalized sector. “We are committed to providing health insurance to our contributors at no additional cost, and we see it as a benefit to them,” he said. Byarugaba says that in addition to health insurance, the NSSF also intends to invest workers’ savings into several profitable ventures, such as apartment buildings that workers would be able buy back at preferential rates. He said it was not possible to make such investments under the current legal regime. “Until the law is changed, we still have to appeal to the Minister of Finance to approve an investment, yet our competitors – who are awaiting licenses – are not restricted in the same way”.

When asked about it recently, Jamwa was pleased to receive confirmation that the idea is still on the table. “I’m a firm believer that social security provision should go hand in hand with health care,” he said, before adding that he wanted to wait to see how the process unfolded before commenting further.

NHIS still alive

Despite the present complex situation, the matter attracted the attention of Parliament’s Health Committee in January 2015, when MPs assigned Dr. Asuman Lukwago, Permanent Secretary of the Health Ministry, the responsibility of formulating a schedule for finalization of NHIS and confirming when Ugandans could expect to benefit from the NHIS. An optimistic Dr. Lukwago claimed that the scheme would become operational by the end of the year (2015).
However, there has been some confusion and opposition to NHIS following statements made by Dr Lukwago’s colleague, Dr. Runumi, to MPs that Ugandans already in possession of private insurance would have to choose between paying double health premiums (by virtue of becoming twice insured) or relinquishing their private insurance and switching to the NHIS, since the State scheme would be mandatory.

The NHIS draft Bill makes provision for the establishment of a new body, the Uganda Social Health Insurance Corporation, which will be responsible for collecting member’s contributions. Dr. Runumi stated. “The plan is to initially cover about 25% of the 34 million Ugandans, whereby employees are required to contribute 4% of their gross salary to which employers add 4% making the total contribution to the scheme 8%. The informal sector will be incorporated into the scheme at later stage through the Community Health Insurance initiative.”

Public concerns
However, the insurance sector remains concerned about the progress of the NHIS, with some privately supporting the NSSF model. According to Miriam Magala, Chief Executive of the Uganda Insurers Association, the NHIS is being forced down their throats. “The Bill does not allow one to choose their own medical insurance provider and by extension, the medical insurance cover they wish to enjoy,” she said. “The key concern of the Law should be that every resident has affordable medical insurance coverage provided by a credible provider, as opposed to a preoccupation on or stipulation of who the provider should be. Contributors should not be denied an element of choice under the scheme.”

Ms Magala adds that the NHIS does not acknowledge existing efforts by private health care providers to ensure quality health coverage for its members. “The object of the Bill should, therefore, be to recognize these existing insurance providers as part of the National Health Insurance Scheme, while providing avenues for increased coverage.”

There are also ongoing concerns about what premiums will be paid to keep the NHIS in business and offer quality healthcare. While the NHIS has not released any official numbers, speculation is that contributions will range from Shs 300,000 to Shs 500,000 per contributor, per year, which insurance analysts think is too ambitious. “Given the current cost of medical care … premiums are hardly sufficient to cover annual medical expenses. A more equitable contribution system needs to be devised, so that many more people can contribute to their medical insurance, rather than just the few in formal employment and the public service,” Magala adds. She concludes by advising the NHIS to require private firms to compete for contributions instead of running one large fund managed by government, to ensure good governance, transparency and proper accountability.
Borrowing lessons from Rwanda

Interview with Ms Rosemary Senabulya, Executive Director, Federation of Uganda Employers

The proposed National Health Insurance Scheme (NHIS) should be divided into three components if the project is to effectively meet Ugandan’s needs, Rosemary Senabulya, the Executive Director of the Federation of Uganda Employers has advised. In an interview, Senabulya said the reason the scheme has failed to take off is because the Ministry of Health is pushing for an ambitious, yet unrealistic, national scheme. “Our proposal, which was not taken on board in the formulation of the current Bill, was that Uganda establishes three schemes: one for the public sector, another for the private sector, and a third for the informal sector. This is the model used in Rwanda, and it has served the country well,” she said. She said each of these schemes would be expected to make a contribution to a central fund, which would meet the health care needs of people who not in position to subscribe to any of the three schemes.

As it is currently formulated, the draft National Health Insurance Scheme Bill proposes a singular, centralized scheme to which employers and employees will respectively contribute 4% of their income. The scheme proposes initially targeting civil servants and formal sector employees who are contributing to the National Social Security Fund (NSSF). Senabulya said it is not advisable to impose an additional burden on employers and employees considering that they are already contributing towards social security. A more prudent approach, in her opinion, would be to deduct and remit for health insurance, a percentage from the 15% contributed to the National Social Security Fund. A similar arrangement could be contemplated for public servants in respect of their social security (pension) contributions. She said that in discussions with Federation of Uganda Employers the NSSF has principally expressed its willingness to surrender a portion of the 15%; however, this would require an amendment to the NSSF Act to include health among the benefits offered by the fund.

Senabulya also wondered how the ministry of Health is expecting the one million subscribers targeted in the initial stages of the scheme to support the approximately 33 million Ugandans who would not yet be contributing towards the scheme. “There is a misconception because people think that when the scheme starts everybody is going to benefit – and this is not the case: initially it is only members who will benefit. People who are not contributing will not be able to claim medical services under the scheme. This suggests that the country is not ready to start offering universal healthcare by means of NHIS.”

Discounting further the argument that government would provide subscription for disadvantaged Ugandans not able to subscribe to the scheme, Senabulya says this is just not feasible. She said a mechanism should be devised to ensure that the public, private and informal sectors all contribute so that government need only cover the costs of the very poor. “Let’s be realistic. If government is struggling to meet the costs of our existing public health care system, where are they suddenly going to get money from now?”

“We should ask ourselves if it is really necessary to create an independent body to cater for healthinsurance or whether it makes more sense to as these institutions given the similarities in their mandates?”
She further questioned whether it is necessary to create a separate Authority to handle health insurance in view of recently established entities such as the Insurance Regulatory Authority and the Uganda Retirement Benefits Regulatory Authority – both of which address social security. “We should ask ourselves if it is really necessary to create an independent body to cater for health Insurance or whether it makes more sense to assign this responsibility to one of these institutions given the similarities in their mandates? This would dispense with unnecessary administrative costs, and significantly reduce the initial capital outlay calculated for the establishment of NHIS,” she observed.

She advised that the Ministry of Health should review all the proposals it received during the consultations to come up with a health insurance model that is simple and thus can immediately be implemented instead of insisting on an ambitious scheme that is prohibitively expensive and difficult to execute.

Her arguments are based on the number of queries pertaining to the Bill that have been raised by the Ministry of Finance, and which the Ministry of Health has reportedly not satisfactorily responded to until now. Senabulya says she doubts the draft Bill can be presented to Parliament soon because of these key issues. “If we really want this Bill, we need to proceed as we initially proposed: by creating three schemes, to be assessed over a period of time, and if we are convinced that it would be beneficial to merge the schemes then we can do so. This is preferable to starting very ambitiously and potentially failing, which may be the reason it has been difficult to implement NHIS to date ” she concluded.
Kampala City Traders Association (KACITA) has cautioned the Ministry of Health from rushing implementation of the proposed National Health Insurance Scheme (NHIS), warning that it risks having the policy rejected if consultations on it are not widely conducted. A Bill regulating the scheme has already been drafted; it is anticipated that it will shortly be tabled before Parliament for enactment. Mr. Everisto Kayondo, Chairperson of Kampala City Traders Association, warns that if the Bill is not carefully and properly marketed amongst relevant stakeholders, such a well-intentioned scheme could easily be rejected. “If it’s presented to parliament and they pass it without prior consultation, let them be sure it will be resisted. That’s the only assurance I can give them.” he warned.

Whereas the ministry of Health says it has conducted extensive consultations since the NHIS was proposed nearly a decade ago, Kayondo says many groups including KACITA have not been approached to submit views on the scheme. Speaking in an interview, Kayondo says while they fully support the scheme, the issue of stakeholder involvement should not be taken lightly if Ugandans are to embrace the policy. “People need to be told of the benefits and costs instead of just slapping a policy on the public without consulting them. It can be challenged and you find some people might not embrace it and once it’s resisted then reintroducing it becomes a challenge. So I would just advise them to involve stakeholders” he added.

Kayondo was particularly concerned about the impact of the scheme on the private sector, which he claims is struggling with some companies having already laid off workers because of the rising cost of doing business in the country. “Already some people are thinking of retiring their employees because they are not able to break-even and if you introduce a policy which is asking them to pay more without consulting them, you can easily hit a snag,” he explained. The Bill proposes that both employers and employees contribute 4 percent of an individual’s remuneration towards the scheme. But Kayondo is worried that imposing an additional burden on employers is not fair, particularly as they are already contributing to employee’s social security through remittances to the National Social Security Fund (NSSF).

He explained that even in developed countries where health insurance schemes have been
perfected, contributions are made by gainfully employed individuals while government contributes for the disadvantaged part of the population. “My only worry is heaping this burden on the employer when he is already contributing for your retirement through NSSF. You have been treating yourself now you want me to treat you just because of the legislation? I think this is why it is important to obtain employers’ consent: they should be provided an opportunity to review their finances to assess whether an extra burden is tenable or poses a risk to the company’s sustainability.”

Kayondo insisted that the largest contribution should come from government because it bears the mandate to provide social services to citizens. He said many Ugandans either have meager or no incomes to be able to pay for all these demands from government. He is confident that if government set its priorities right, it would have the money to pay health insurance for citizens. “They can pay if they are serious because if you look at what they are swindling then you will know how it is.” he noted.

He also holds the view that the scheme should be piloted to test the capability of existing health institutions to effectively implement it. The city traders’ leader says rolling out the scheme on a massive scale could force some accredited health units to compromise the quality of service offered if they became overwhelmed.

“Just look at these public hospitals we currently have, where patients are tossed around because the hospitals have to handle too many patients. If we overburden service providers before they are improved, we are not likely to get value for money.” he advised.
Citizen voices: Ordinary Ugandans speak out on the proposed National Health Insurance Scheme.

By Joshua Kisawuzi

Kisengwa David of Mukono Municipality

“I am not aware of the scheme but if implemented, it will help the citizens who cannot afford treatment for complicated health problems.”

Musisi Edward

“It might not be different from other government programs that benefit a few like the elderly program.”

Mailut Mawanda

“It will be good if it considers the local people. It might end up benefiting the rich people.”

Emmanuel Magyezi of Ntungamo

“I am not aware of the scheme, but it can be good if the government handles it responsibly and not like other programmes like NAADS.”

1. ISER Community Outreach Officer
Nabukeera Agnes

“Government must weed out corrupt officials first to avoid its mismanagement.”

Sekikongo Kizito of Mityana District

“If it is started, it can be good but due to corruption in the country it will end up in shambles.”

Sekiwunga

“I have doubts about its effectiveness, people have given up on government programmes.”
National Health Insurance should prioritize vulnerable communities

By Charles Ebunyu

Uganda has to contend with many communicable and non-communicable diseases, which have had a greater negative impact than may have been the case with a more comprehensive and effective public health care system or National Health Insurance Scheme (NHIS). For example, leprosy and hydroceles, both common diseases in Uganda’s Northern districts of Otuke, and Alebtong, could be more effectively treated and efforts put in place to curb and ultimately eradicate them; but this is not possible in the absence of a NHIS.

While some elites may appreciate the need for medical insurance, prohibitive costs prevent them from taking out private health insurance policy. Among the rural population, which makes up about 80% of the population, there is an even lower rate of subscription to private health insurance due to an overwhelming lack of knowledge about medical insurance but here too prohibitive costs are an even stronger disincentive to membership.

Though there is a provision in the proposed NHIS Bill for people who are neither civil servants nor contributors to the National Social Security Fund (NSSF) to make contributions under Community Health Insurance Schemes (CHIS), this is going to be very hard for majority of people from northern Uganda. The effects of the two decade civil war between the Lords Resistance Army rebels of Joseph Kony and the Government of Uganda forces are still visible. Populations that were displaced during the conflict still suffer from limited access to livelihood opportunities while some are still physically and mentally scarred. The health infrastructure in this region is wanting with many facilities lacking basics like water and sanitation facilities.

1 Charles Ebunyu works with the Lira NGO Forum

1 Getting it Right: Uganda’s Proposed National Health Insurance Scheme
No coordinated initiative to educate people about NHIS has been rolled out across the country, which is why many Ugandans assume that it is only well-established Non Governmental Organizations (NGOs) and UN Agencies that provide health insurance to their employees. Discussions relating to NHIS have been largely restricted to the press, which has restricted the spread of information to literate elites who can afford media publications. Radio and television discussions of NHIS, especially in local languages, would thus be highly beneficial to breach this information gap in so far as poorer, less sophisticated and illiterate Ugandans are concerned.

It is important to inform all segments of Ugandan society about NHIS and to encourage their support of the initiative because health risks (and the treatment thereof) are national priorities given that the right is a social good. The marginalization of poor and rural communities from public health interventions can no longer be tolerated. The level of disease transmission in rural communities is very fast and there is inadequate human and infrastructural capacity at community level to fight these diseases. This is compounded by environmental factors such as poor hygiene and sanitation conditions, dirty, contaminated water pools, and large forests and bushes which act as fertile breeding terrain for the bacteria and viruses that cause and spread diseases. All of these considerations – in addition to concerns of livelihood, access to food, etc. serve to compound the health vulnerability of rural communities.

To implement a health insurance scheme without increasing the existing number of staff in the public health sector would require the following; training of Village Health Teams (VHTs) to provide more comprehensive information about the benefits of insurance; Health Centre IIIs provide an appropriate opportunity for all the citizens in a particular sub county to get health insurance; designation of Health Centre IIIs as implementer of health insurance at sub county level. If, however, in genuine good faith, the government of Uganda cannot provide health insurance to all its citizens, it would be prudent to ensure that the most vulnerable communities are covered first while other working classes are mandatorily asked to commit funds to secure health insurance for their families. Development partners could also be requested to supplement local resources and cover any shortfalls.

“...it would be prudent to ensure that the most vulnerable communities are covered first...”
Fundamentals for achieving universal health insurance in Uganda

By Annette Were Munabi

Good health is considered instrumental in facilitating socio-economic transformation. While Uganda has made tremendous efforts in improving the health conditions of its population, the progress has been slow. Currently, Uganda's health service delivery is a decentralized role which relies heavily on conditional transfers of funds from the central government for implementation of programs. This has proved expensive, inefficient and not sufficiently responsive to the health needs of the different categories of the population.

Uganda's dependence on a facility-based health service delivery system excludes the extremely poor and vulnerable either by age, social class, location, disability, gender, disaster or lack of income. While health centers have sprung up at local government level, they remain inaccessible to many rural communities. Coupled with several challenges such as under-funding, inadequate staffing and regular shortages of essential medicine and medical supply stocks, there has emerged the need to re-think the entire approach for health service delivery.

Government's medium to long term plans include shifting from a facility-based to a household based health service delivery system through public-private partnership arrangements. Additionally, the government intends to move towards the preventive health system which is considered cheaper and far more sustainable in the long run than the curative one.

Equity and financial sustainability

Universal health coverage has in the recent past become a global concern. The Ministry of Health (MOH) has been committed to implementing the strategies of the National Health Policy II (NPH II), as well as achieving the targets in the National Development Plan and the MDGs. These were designed with the prediction of achieving equity, efficiency and sustainability. Since the abolition of user charges at health facilities, government has been consistently faced with the constraint of inadequate funding of the social sectors and the national budget at large. Although insurance schemes have the potential to improve access, they are limited in scope despite several development partners’ efforts to supplement government through incentives.

In response, the MOH recommended a minimum health package that can be delivered to all people of Uganda within the available resource envelope. To complement this, the Government is in the process of developing the legislation for national health insurance. The legislation aims at improving access and quality of health care services through a complementary financial mechanism. To kick start the process, Uganda's proposed national health insurance scheme is limited to public servants and the labour force in formal employment, in contrast to Kenya where membership is open and voluntary to retirees and those in the informal sector. Mandatory monthly financial contributions of 4 percent of the earnings of those in formal employment will be equally supplemented by the equivalent contribution by employers irrespective of variations in income levels. The regressive nature of such a mechanism is likely to increase the burden to the contributors who in essence are the largest income taxpayers. Such a funding mechanism

1 Annet Munabi is a socio-economic policy analyst

Getting it Right: Uganda's Proposed National Health Insurance Scheme
does not follow the ordinary insurance model in which a premium is paid by individuals/groups for a selected package depending on their need and affordability. Instead, it sets a standard rate which is likely to become a disincentive for the contributors and hence compromise the sustainability of the scheme.

In Rwanda, a comprehensive insurance reform enacted in mid-2011 transformed the community-based health insurance scheme (Mutuelle de Santé) to a system of tiered premiums to make it more financially progressive and sustainable. It is crucial that variations of health risks associated to different age groups, household size and geographical locations among other things be carefully considered in formulation of a funding model for the scheme.

**Inclusion**

Uganda's health scheme will cater for only four (4) dependents of each beneficiary; this is exclusionary considering the large size of the majority of Ugandan households. Additionally, the legislation requires that the majority of Ugandans who are not members or beneficiaries of the scheme be registered with a community health insurance scheme. Voluntary enrolment for insurance is determined by the individual's social-economic status, social capital and government's enforcement. While it may be feasible and cost-effective to compel those in formal public and private employment into the scheme, it lacks a clear articulation of the inclusion strategy for those in informal employment, who include un-employed youth, the elderly and the rural poor. Government will require stringent and elaborate enforcement laws and mechanisms for those in the informal and subsistence sectors. For example, Rwanda's universal health coverage scheme registered enrolment of over 90% within the first 10 years of implementation. The success is largely attributed to governments’ enforcement of the health insurance laws with regulations.

**Operational and implementation effectiveness**

Health service delivery under the national health insurance scheme will be through the "capitation" mechanism. Negotiations will be between the Scheme and a health care provider and thereafter, the health care provider will be responsible for delivering or arranging for the delivery of the required health services in accordance with the contract, and at a fixed rate. This calls for sound macro-economy; to ensure stable and low prices and competitive foreign exchange rates considering that the majority of medical supplies are imported. In developing an operational framework that will enhance diagnostic accuracy, provider compliance and consumer adherence as well as wide consultations with all stakeholders will be enriching. A multi-sectoral regulatory and oversight authority must be in place from the start to ensure that governance related problems such as corruption and the rampant in-efficiencies associated with public institutions do not emerge. In developing the alternatives of insurance packages, participatory appraisals with the different groups of society are crucial to avoid the “one size fits all approach” as has been the case with some existing development programmes.

Historically, contributory, risk-pooling endeavors from community health schemes have existed with variations in operational and institutional arrangements depending on the local context. However, there is need to support the groups to structure community-based activity as insurance in order for them institutionalize and sustain their activities.
Clause 8 of the proposed National Health Insurance Bill 2012 provides for the creation of Community Health Insurance Schemes (CHIS). The CHIS is to cater for persons who are neither civil servants nor contributors to the National Social Security Fund (NSSF). The Bill defines CHIS as a not-for-profit health insurance scheme established in the informal sector and created on the basis of an ethic of mutual aid and collective pooling of health risks in which the members of the scheme participate in its management.

CHIS is not a new phenomenon in Uganda. The Initiative for Social and Economic Rights (ISER) sent a team to the districts of Rukungiri and Kanungu led by Fiona Orirkiza from the Public Interest Litigation Clinic of the School of Law at Makerere University to document the experiences of the CHIS in the area that different informal sector groupings in various parts of Uganda could learn from.

Communities in the districts of Rukungiri and Kanungu subscribe to a concept known as Bataka Kwezika, which means ‘let us bury ourselves’, a term which refers to the burial groups formed by communities coming together to support bereaved families with the preparations and financing of burial-related activities. This is the mother concept upon which CHI is premised.

The different stakeholders involved in implementing CHIs, sensitized communities to use the concept of Bataka Kwezika, to form preventive measures such that instead of coming together to help out a family that has lost a dear one, they come together to prevent unnecessary deaths due to the lack of adequate healthcare. Therefore deaths by pooling funds and enabling members to access healthcare services for the good and benefit of everyone and the community at large. To them, CHI is health insurance that pools members’ premium payments into a collective fund, which is managed by the members, and covers basic health care costs at local health centers and hospitals when a member is sick. “Now the CHI scheme helps us to get treated when we get sick rather than waiting until we die to support our funerals,” one member said.
How are members organized?
One must be a member of a community. Individuals from the community come together to form a User Group. There must be a membership of at least 10-20 families for each User Group to ensure adequate pooling of resources. Members include farmers, local business persons, widows, teachers, some civil servants and other community members. Different CHIs, at different centers, have different rules that govern membership; however what is common among all is that at least 60% of the Bataka group families must subscribe to such a scheme and 100% family members of a family on the scheme must be subscribed. The reason 100% family subscription is required is that since the premiums are relatively low per head, if families had the discretion to select who to insure, only the sick would be enlisted and the fund would become swiftly depleted. Hence those who generally enjoy good health subsidize people who are sicklier.

The User Group administration bears the responsibility of collecting premiums and making payments to the health centers that provide services; health centers and hospitals are not involved in the management of funds. Families obtain access cards which bear the photos of insured members on one side and corresponding names of all the family members on the other side. More advanced schemes have computerized systems with thumb print identification.

Who implements?
CHIs are implemented by the health centers and hospitals that formulate the schemes. In all schemes studied, the health center/hospital were both the service provider and the insurer. These centers tend overwhelmingly to be affiliated to a church. In the schemes studied, affiliations were to Church of Uganda, Catholic Church, and the Orthodox Church. However, membership to the scheme is not dependent on one’s religious beliefs – all members of the community, provided they are able to meet the financial requirements, have access to CHI.

Premiums:
CHIS subscriptions are generally paid in cash, as a one-off annual payment or on a quarterly or bi-annual basis – the decision as to which depends on the scheme provider, implementing partners, and the capacities of the communities in question (generally ascertained by means of a review). The quarterly system was introduced to ease the pressure on subscribers who would otherwise have been required to produce a significant sum of money all at once, which would likely have precluded a large

Sample of a health insurance card for Nyamwegabira Central Group, Nyamwegabira Community Health Insurance in Kanungu District.
number of interested people simply because such a requirement is prohibitive given peoples socio-economic circumstances.

Premium rates differ from provider to provider; but rates tend overwhelmingly to be higher in urban-based health centers. At Bwindi Community Hospital in Kanungu District, the annual premium is Ugx 10200, paid in three installments of Ugx 3700 every four months. At every visit members are required to pay an additional small processing fee ranging from Ugx 1000 to 3000 for out-patients and Ugx 2000 to 6000 for in-patients.

**Coverage:**
In terms of health benefits, CHI primarily covers essential health service packages at the health center level. The benefits include both inpatient and outpatient services. At Nyamwegabira Health Center III, inpatient services are provided up to three weeks, at a fee of Ugx 6000 for all the insured. All types of essential health services that would be covered through out-of-pocket spending at time of sickness are covered by CHI schemes, including emergency surgeries, antenatal care and post natal care. At Kisizi Hospital in Rukungiri District, all the members on health insurance get free consultations with specialized doctors like the gynecologists and surgeons while the rest of the patients have to pay Ugx 30,000 to see such doctors. At the same hospital, for non-emergency surgeries, the insurance policy meets 50% cost and the member meets the other 50%. At the time of the interview, a beneficiary under the scheme was in hospital to attend to his son who had just had a Hernia operation. The bill was Ugx 900,000 but was only going to pay Ugx 450,000. CBHI does not cover luxury treatments like cosmetic surgery, teeth whitening and planned surgeries.

As discussed in the foregoing, all family members must be subscribed and a participant must belong to a *Bataka* group. This is an all inclusive scheme that does not select or require a family to only insure four dependants as suggested for the proposed NHIS.

---

*Batwa women have lunch at their craft workshop in Bwindi. The money from crafts sales pays for their Community Health Insurance Scheme at Bwindi Community Hospital*
Serving indigenous communities like the Batwa
The Batwa people are some of the beneficiaries of the CHIS in Kanungu District. They are an indigenous community who became homeless about 20 years ago when they were evicted from Bwindi Impenetrable Forest. The population of the Batwa in Bwindi is 804 people according to the information received from an interview with the Bwindi Community Hospital Principal Administrator Canon Rev. Charles Byamugisha. These Batwa are all registered on the eQuality health insurance policy administered at the Bwindi Community Hospital and this has been achieved through private partnerships with the Batwa development program. This is a program aimed at empowering the Batwa financially by providing ready market for their crafts. The profits from the sales are deposited into the Bwindi Development Program account to fund projects such as education and health care. This is how the Batwa people access health insurance.

Stakeholders:
Uganda Community Based Health Financing Association (UCBHFA), Uganda Catholic Medical Bureau, Uganda Orthodox Medical Bureau, and Uganda Protestant Medical Bureau are just some of the associations that have been involved in the administration and implementation of different CHIs, and have amassed significant knowledge that could be shared with government in the implementation of NHIS.

Recommendations:
The move by the government to introduce a national healthcare system is commendable; however, before looking outside Uganda, we should look to the health insurance schemes operational in different areas of the country, for example Western Uganda, where the government could study and understand the mode of operation and borrow from the best practices used in this and other regions. Similarly, Uganda could also learn from its neighboring countries, such as Rwanda, to understand how to incorporate the CHIS into the NHIS. CHIS should complement the NHIS since it is better positioned to deal with the informal sector. CHIS should be one of the branches represented on the NHIS administrative board, whose role should include regulatory and supervisory responsibilities and not merely the collection funds as currently proposed.
After attaining independence in 1957, Ghana adopted a health care system founded on a socialist ‘free health-care’ model. In 1972, the government introduced a token health facility user fee to support the model. However, Ghana's economic crisis in the 1980's forced government to accept a bitter World Bank programme which, in 1985, introduced a fully-fledged user fee scheme, referred to colloquially as ‘Cash and Carry’. The ‘Cash and Carry’ system resulted in patients having to dig deep into their pockets to pay for health care – even emergency procedures were contingent on fees being paid up front. While the intention of the ‘Cash and Carry’ system was to generate a 15 percent hospital operating cost, it ultimately contributed to an increase in the inequality gap between rich and poor, prompting almost half of the country's population to self medicate or resort to traditional herbal healing.

Years later, in 2005, Ghana's National Health Insurance Scheme (NHIS) finally became fully operational following a political promise made by the opposition party in 2000. The NHIS was an attempt to ensure national access to healthcare irrespective of socio-economic status.

Financing the scheme
Ghana's National Health Insurance Scheme, which is administered by the National Health Insurance Authority, is financed by means of the following: i) a health insurance levy imposed on all Ghanaians; ii) 2.5% Value Added Tax (VAT) on all taxable goods and services; 2.5% monthly pension contributions of formal employees (which was achieved after tough negotiations with labour unions); and a nominal, annual premium imposed on informal-sector workers, which is not higher than 20 USD in 2015.3

Certain categories of people are exempted from making contributions to NHIS: persons aged 70 and older; persons younger than 18 years; as well as indigent persons. The Ministry of Finance makes provision for an NHIS budget to cover exempted persons.
The fund is also supplemented by grants, donations, gifts, and other voluntary contributions.

Successes
Since its inception, the NHIS has recorded a number of successes. Firstly, the active membership of the scheme has increased substantially since its inception in 2005, from 1.35 million to 10.14 million as at December 2013, representing a growth of over 650 percent.4 Outpatient utilization of health care...
services in respect of NHIS subscribers also increased significantly from 597,859 in 2005 to Nine 9,339,296 by December 2008 and 27,350,847 by end of year 2013. Similarly, Inpatient cases also increased from 28,906 in 2005 to 617, 231 in 2008. As at December 2013 inpatient cases has risen to 1,610, 622. The scheme covers all outpatient costs, namely comprehensive essential drugs, essential laboratory and X-rays services, oral and dental services as well minor surgeries (e.g. removal of hernias, etc.). Cancer treatment, heart- and other major -surgeries are not covered under the scheme.

After several piloting schemes, maternal health care services, including caesarean procedures are now provided by the NHIS at no additional fee. National figures show that following the implementation of the NHIS, institutional birth deliveries increased while maternal mortality figures reduced. Malaria deaths for children under five years notably reduced by half while child and infant mortality rates also declined after years of stagnation.

Obstacles
During the initial stages of the NHIS, there were reports of scheme members having to wait for 3-6 months to be issued with insurance identity cards, a prerequisite to access healthcare services. Consequently, some members could only access health services for six months despite making contributions for a full year. This resulted in a steep decline in the number of active users, as many members lost interest in renewing their subscriptions. The NHIS annual report 2010 showed a decline of active membership from 10,638,119 in 2009 to 8,163,714 in 2010. To resolve this problem, the National Health Insurance Authority (NHIA) implemented a new roll-out programme by means of which members were issued with identity cards immediately after registration.

Another challenge, raised in reports by Oxfam and other NGO's, was the alleged exclusion of Ghana's poorest from the enjoyment of NHIS services. On this basis, stakeholders called for government to terminate annual premiums, as the government was failing in its responsibility to give expression to the right to health insofar as indigents were concerned, which was leading to ever widening social inequality. The group of NGO's argued that because it was difficult to identify indigents, some religious organisations and NGO's have found ways of identifying them to pay up their premiums hence their existence on the scheme were tied to the benevolence of other organisations. The group further suggested that since all Ghanaians paid 2.5 percent taxation on all taxable goods and services, government should make a commitment to remove premiums and rather find alternative sources funding: especially taxing the “evasive” extractive industry and also divert oil revenue to sustain the scheme. Clearly, this suggestion is unsustainable and would create a serious financial gap because government has already projected a GH¢ 347 million (90,129,870 USD) gap in 2015 to reach a projected gap of GH¢ 803 million in 2018 if creative ways are not found fund the scheme.

---

5 As above
7 Addressing the Health Needs of Children and Youth in Ghana – Challenges and Prospects
9 NHIA: National Health Insurance Scheme Annual Report 2010
11 As above n 4
In response, to identifying indigents, Ghana’s Ministry of Gender and Social Protection is currently using a poverty reduction programme called ‘Livelihood Empowerment Against Poverty’ (LEAP) to more effectively target the very poor. Although, the programme has not identified all indigent persons, this step to identify and make provision for the needs of the poor should be commended.

A third challenge identified in the early stages of the implementation of NHIS related to reports that some pharmacies withheld prescriptions by deceiving patients into believing that prescribed drugs were not on the NHIS medicine list. In this way patients were compelled to pay for medication to which they were entitled under the NHIS; and unscrupulous pharmacies still billed the National Insurance Authority for reimbursement. In response, government published the medicine lists to inform patients of the drugs covered by the NHIS.

There were also reportedly delays by the government in processing and paying out reimbursements to hospitals that incurred costs for treating registered NHIS members. The delays adversely affected many hospitals, some of which even threatened to suspend implementation of the NHIS in their facilities.

**Assessment**

Despite these hitches in Ghana’s implementation of the NHIS, the programme has proven highly successful in providing poor people in Ghana with access to quality healthcare. Countries attempting to establish health insurance could learn some valuables lessons from the Ghanaian experience.

**Lessons for Uganda**

- Uganda should find innovative, sustainable ways of creating revenue streams for the proposed health insurance before the scheme is rolled out.

- Uganda should develop good administrative processes to prevent corruption to avert health funds being diverted into private pockets.

- Uganda must carry out programmes to identify, process and facilitate the inclusion within the NHIS of the very poor; else the programme has the potential to widen social inequality.

- Uganda must publish lists of medicines covered under the health insurance scheme to avoid users being duped by suppliers.

- Similarly, the list of health centres providing services under the scheme should be publicised early to empower scheme members to claim services to which they are entitled.

- Systems should be put in place to expedite the processing and payment of reimbursements to health facilities, to avoid financial pressures jeopardizing institutional sustainability.

- Some key private hospitals and pharmacies must be accredited early enough to provide health care to avoid patients congesting limited government health institutions.

“Uganda must carry out programmes to identify, process and facilitate the inclusion within the NHIS of the very poor; else the programme has the potential to widen social inequality.”
Concerns over Kenya’s financing for Universal Health Coverage that Uganda could learn from

By Dr. Vincent Okungu

Kenya, like many developing countries around the world, is in the process of reforming its health system with the objective of providing free health care for all at the point of service. To achieve this objective, the Ministry of Health has held several policy discussions over the most appropriate financing strategy. Although the universal health policy is yet to be launched, bits and pieces are already in place. These include the financing mechanism for universal health coverage (UHC), contribution rates for all population groups and the institution to manage pooled funds.

The Kenyan Government's official policy for financing Universal Health Care (UHC) comes in the form a contributory mechanism. The contributory system in question emphasizes premium payments through Social Health Insurance (SHI). Under this arrangement, formal and informal sector workers as well as formal-sector pensioners contribute premiums on a regular basis. The informal sector is expected to contribute a flat-rate of KSh 500 (US$ 5.44) per month per household and a similar rate is paid by the government on behalf of the indigent population. The formal sector pays on average 2.4% of their gross salary. The funds are pooled such that the above-mentioned groups all draw down on the same resources.

Pooling resources into a singular fund is important for economies of scale and to ensure the equitable access of different socioeconomic groups to specified package of health services. Although the Kenyan approach to UHC cannot be evaluated at this time since it has not been fully implemented, there are unanswered questions regarding the policy that other countries could learn from, particularly given the fact that the majority of Kenya's population targeted for coverage is in the informal sector.

The first concern relates to the choice and design of SHI as the financing mechanism to UHC. SHI requires predictable incomes from the contributing population in order to sustain health programs. It also needs strong popular support because of the difficulty in enforcing SHI in the informal sector where incomes are not easily identifiable.

Recent empirical evidence(by this author) indicates that incomes, particularly for the non-agricultural informal sector in Kenya are quite unstable, which would make regular premium payments under SHI unpredictable given that informal economic entities struggle to sustain themselves and raise income for their workers. Likewise, although the agricultural informal sector shows less disruption in income, the earnings are very low if at all, such that the workers in this sub-sector might find it difficult to cope with demands for regular premium payments. In other words, there is no clear justification for the choice of SHI as the mechanism for financing UHC in Kenya.

“Enforcing informal sector enrolment into contributory schemes is easier said than done.”

Wider academic literature further indicates that SHI is associated with gradual growth, which requires formalization of labor to increase population coverage and progress to UHC. Formal labor is required because contributions to SHI schemes are most effectively implemented through salary deductions. Where labor is informal, it is not easy to implement SHI owing to the difficulty of enforcing enrolment.

1 Dr. Okungu is a consultant health economist, an academic and expert in program-based budget

Getting it Right: Uganda’s Proposed National Health Insurance Scheme
and estimating informal sector income. Among low- and middle-income countries, SHI as the main financing mechanism has not strictly succeeded in advancing UHC; where it has, for example in Costa Rica, it functions as a mechanism for creating single-risk pool and single-purchaser coverage.

Enforcing informal sector enrolment into contributory schemes is easier said than done. In Kenya, although the proposed scheme specifies strategies to make it convenient for informal sector membership and contributions, there is very little detail regarding how this will be enforced. Relevant experience from developing countries shows that although membership to contributory schemes could be mandatory by law, they often remain largely voluntary in practice and chances are high that the Kenyan UHC system could go the same way. This would make population coverage and progress to UHC difficult. Secondly, the SHI system is prone to self-selection in which those most in need of health services are likely to enroll into the scheme. Self-selection is costly and potentially threatens the sustainability of schemes. Self-selection also occurs where only those able to contribute become members. In other words, the contributory model in the context of large informal sector populations would perpetuate inequities where access to care is based on ability to pay rather than need.

Such potential inequities under a contributory mechanism are further exacerbated by grossly maladjusted contribution rates. The current rates meant to anchor UHC under the National Hospital Insurance Fund (NHIF) are unacceptably punitive against low-income earners. For example, the lowest income earner in the formal sector contributes 5% of their gross income per month while the highest earner, say a worker earning KSh one million, contributes a paltry 0.17% of gross pay. The key weakness in the constitution NHIF rates is that they are capped at KSh 100 000 gross pay beyond which contributors increasingly pay less. If the caps are removed, the NHIF could potentially collect close to double its monthly revenue as a result of contributions being adjusted upwards according to income rather than remaining static for all salaries beyond KSh 100 000. Current NHIF rates are random figures that are not anchored in any scientific methodology.

More generally, premium payments to SHI are regressive for all contributors because either contributions are flat-rated, for example in the informal sector, or are capped for formal sector contributors. The regressivity of contributory financing systems has persuaded countries such as Spain and Iceland to abandon SHI in favour of tax funding for UHC. In a sentence, the impracticality of SHI, particularly in settings with large informal sector populations, has influenced a number of scholars to recommend alternative methods such as improving efficiency in tax collection and introducing indirect taxes to target informal sector resources to advance UHC rather than direct premium contributions by the informal sector. There are serious doubts about the long-term sustainability of SHI in the stated context of informal sector work.

Funding UHC from taxes (or general government revenues) has increasingly gained attention as a more viable option than SHI in attaining UHC in developing countries. A number of advantages are associated with extending coverage using general government revenues. First, government funding supports equity in financing and benefits as they are more progressive and easily target the whole population from a single large pool at an administratively lower cost than SHI. By targeting the whole population, tax funding successfully integrates different socioeconomic groups by standardizing the benefits package and simultaneously allowing richer people to self-selectively opt for private services while still contributing to the tax pool for the benefit of low-income groups. What this means is that tax funding supports institutional universality and is more equitable in its
universalist approach than targeted coverage. Tax funding is therefore, an option that African countries should seriously consider during reforms of health systems for UHC.

The tax-funded approach to financing UHC should be supplemented and sustained by a number of other key considerations including political commitment to UHC in order to secure funds for the health sector and expand coverage; economic growth rate which is essential in increasing health sector funding without interfering with funding for other government sectors; active purchasing and improved provision of public sector services; and continuity, and oversight roles of various actors to prevent fraud and sustain funding for the health sector. These are the most essential components for progress towards UHC.
About the Initiative for Social and Economic Rights - Uganda

**ISER** is a registered national Non-Governmental Organisation (NGO) in Uganda founded in February 2012 to ensure full recognition, accountability and realization of social and economic rights primarily in Uganda but also within the East African region.

**Contact information**

Initiative for Social and Economic Rights (ISER)
Plot 60 Valley Drive, Ministers’ Village, Ntinda
P.O Box 73646, Kampala - Uganda
Email: Info@iser-uganda.org
Website: www.iser-uganda.org
Tel: +256 414 581 041
Cell: +256 772 473 929

Follow us: @ISERUganda @ISERUganda